SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
CRIME VICTIMS COMPENSATION PROGRAM
515 Fifth Street, N.W., Suite 203
Washington, DC 20001

APPLICATION FOR CRIME VICTIMS COMPENSATION

CLAIM NUMBER:_____

INSTRUCTIONS

1. Please type or print clearly in ink.
2. If you need more space, attach additional sheets.
3. If you need assistance completing the form, call 202-879-4216 or come to the Crime Victims Compensation Program at the address listed above.
4. Attach all medical, hospital, and/or funeral bills and submit them with your application. This will help the processing of your application.
5. The application must be signed by the claimant. If the claimant is under 18 years of age, the application must be signed by the parent or guardian.
6. In the event of the death of the victim, please complete Section 4. Up the $3,000 may be awarded for funeral expenses resulting from the crime.
7. DO NOT INCLUDE costs for lost or damaged property or for pain and suffering. They are not covered by D.C. Law.
8. If you do not know the answer to a question, please write "unknown" in the space provided.
9. Please sign the Authorization For Release of Information.
10. The penalty for knowingly submitting false information or withholding important information relating to your claim for compensation may result in forfeiture of compensation, a $2,000 fine or imprisonment for one year, or both.

I am filing this application because I am/was:

- ☐ The victim of a crime.
- ☐ Trying to help a crime victim or police officer.
- ☐ Trying to prevent a crime or apprehend a person suspected of committing a crime.
- ☐ The surviving dependent of a crime victim or person administering the victim's estate.
- ☐ The parent/guardian of a crime victim under 18 years of age.
- ☐ The guardian of an incompetent crime victim.
- ☐ A household or family member of the victim.
- ☐ A person who legally assumed the obligation, or who voluntarily paid the medical or funeral expenses of the victim.

The is an application for:

- ☐ Loss of Earrings
- ☐ Loss of Support
- ☐ Loss of Services
- ☐ Medical/Dental Expenses
- ☐ Funeral Expenses
- ☐ Occupational Therapy
- ☐ Mental Health Services
- ☐ Crime Scene Clean-up ($1,000 limit)
- ☐ Replacement Value of Clothing Kept as Evidence ($100 limit) No reimbursement when the victim is deceased
- ☐ Temporary Emergency Housing For Battered Partners and Their Children (90 day limit)
- ☐ Other:_____

SECTION 1 - CLAIMANT INFORMATION

(A separate application needs to be completed for each victim)

Claimant's Name		Relationship to Victim		
Street Address (Mailing Address)	City	State	Zip Code	Ward
Home Telephone Number	Work Telephone Number			
Date of Birth	Social Security Number			
Additional Means to Contact Claimant				

Victim (Person injured as a result of violent crime if different than claimant)				
Street Address (Mailing Address)	City	State	Zip Code	Ward
Home Telephone Number	Work Telephone Number			
Date of Birth	Social Security Number			

The following information concerning the victim is used for statistical purposes only.
The victim is/was:

Handicapped:	Primary Language:	Race:	Who referred you to the compensation program?
☐ Yes ☐ No Gender: ☐ Male ☐ Female	☐ English ☐ Spanish ☐ Other _____ *(Please Specify)*	☐ Black ☐ White ☐ Hispanic/Latino ☐ Native American/Alaskan ☐ Asian/Pacific Islander ☐ Other:_____ *(Please Specify)*	☐ Law Enforcement Agency ☐ U.S. Attorney's Office ☐ Department of Justice ☐ Hospital ☐ Media (T.V., Radio, etc.) ☐ Other:_____ *(Please Specify)*

SECTION 2 - CRIME INFORMATION

1. Type of Crime (please check one)

☐ Arson	☐ Domestic Abuse	☐ Homicide
☐ Assault	☐ Kidnapping	☐ Car Jacking
☐ Sexual Abuse	☐ Robbery	☐ Drunk Driving
☐ Cruelty to Children	☐ Reckless Driving	☐ Other:_____ *(Please Specify)*

2. Date of Crime	3. Date Crime Reported	4. Agency to Which Crime Was Reported
5. Police Complaint Number		6. Officer's Name

7. In cases of domestic abuse, please indicate Civil Protection Order number (if applicable)

8. In cases of sexual assault, medical treatment facility name (if applicable)

9. Name of Offender(s)

10. Did victim know offender(s)? ☐Yes ☐No If YES, in what way? _____

11. Brief Description of crime

_____

_____

_____

_____

12. Location of Crime (Street Address)	13. City	14. State	15. Country

SECTION 3 - MEDICAL INFORMATION

1. Please briefly describe injuries:

_____

_____

_____

2. Please list all medical/mental health counseling expenses incurred as a result of this reported crime, including hospital and doctor charges, ambulance fees and prescription medications. Please attach itemized billing statements. Each bill must show provider's name, address and telephone number, with dates and type of service. Attach additional sheets if necessary.

Name of Doctor, Hospital or Other Provider of Service	Address	City/State/Zip	Phone Number	Amount of Bill
a.				
b.				
c.				
d.				
e.				

YOU MUST SUBMIT COPIES OF ALL AVAILABLE BILLS RECEIVED TO DATE.
Please attach all insurance payment statements and matching rejections

3. Will there be additional medical/mental health bills? ☐YES ☐NO ☐UNKNOWN

SECTION 4 - FUNERAL EXPENSES (Limit $3,000)

Are you seeking reimbursement for funeral expenses?
☐YES ☐NO If YES, please attach a copy of the funeral bill.

Name of Funeral Home

Street Address City/State/Zip

Total Amount of Funeral Bill: $_____ Have the funeral expenses been paid? ☐YES ☐NO

If YES, by whom?_____

SECTION 5 - LOSS OF SERVICES AND EXPENSES FOR SUBSTITUTE SERVICES

Please list all services such as child care and housekeeping that are no longer available to you as a direct result of the violent crime.

Expenses Incurred

1._____ $_____

2._____ $_____

3._____ $_____

4._____ $_____

SECTION 6 - LOSS OF WAGES/LOSS OF FINANCIAL SUPPORT

Fill out only if claimant or victim was employed at the time of the crime and a loss is being claimed

Victim's Employer (at time of crime) _____
Name

_____
Street Address *City* *State* *Zip* *Telephone Number*

Gross Salary $_____ per: ☐ hour ☐ day ☐ week ☐ month Hours Worked_____ per: ☐ day ☐ week

How long was victim medically disabled and unable to work as a result of the crime/injuries?

From_____/_____/_____ Through _____/_____/_____
Mo. *Day* *Yr.* *Mo.* *Day* *Yr.*

Days off for which victim received compensation in the form of accrued sick/vacation leave.

From _____/_____/_____ Through _____ /_____/_____
Mo. *Day* *Yr.* *Mo.* *Day* *Yr.*

Doctor who can verify length of disability to work:

_____
Doctor's Name *Street Address* *City* *State* *Zip* *Telephone Number*

Applicants for wage loss/loss of support must attach a copy of their Federal Income Tax Returns for the preceeding 12 months.
Indicate below all other sources of income

Description	If YES, Name and address of payer	Income Amount	Paid How Often
☐ Interest or Dividends			
☐ Unemployment Compensation			
☐ Pensions and Retirement			
☐ Annuities			
☐ Social Security			
☐ Public Assistance			
☐ Veteran's Benefits			
☐ Other (describe)			

Has victim applied for or does victim qualify for:
Worker's Compensation? Applied: ☐YES ☐NO Qualifies: ☐YES ☐NO
Other Disability? Applied: ☐YES ☐NO Qualifies: ☐YES ☐NO

If YES, name of program(s):_____

SECTION 7 - DEPENDENTS

(Submit copies of birth certificates for children)

Please complete the following information about dependents. (Dependent means a person wholly or partially dependent upon a victim for care or support and includes a child of the victim born after the victim's death.)

Dependent's Name	Date of Birth	Address	Relationship to Victim
1.			
2.			
3.			
4.			
5.			

SECTION 8 - INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION

Awards may be decreased by the amount of funds available through collateral sources.

Source	YES	NO	Status of Application	Amount Paid
Health Insurance				
Automobile Insurance				
Workman's Compensation				
Medicare				
Medicaid				
Veteran's Administration				
Public Assistance				
Vacation/Annual Pay				
Sick Pay				
Disability Pay				
Dental Insurance				
Life Insurance				
Burial Insurance				
Unemployment Benefits				
Social Security				
Other (specify)				

SECTION 9 - RESTITUTION

If the court has ordered the offender to make restitution to you (pay you back) complete the following:

Date of Restitution Order	Court	Amount
_____/_____/_____ *Mo.* *Day* *Year*		$

SECTION 10 - EMERGENCY AWARD

Is an emergency award sought? ☐ YES ☐ NO
(The law allows up to $1,000 where undue financial or emotional hardship will result if an emergency award is not made.)

If YES, amount sought $_____
Why do you feel you need emergency financial help:

_____

_____

SECTION 11 - TEMPORARY HOUSING

Is this an award for temporary housing for battered partners and children? (90 day limit) ☐ YES ☐ NO

If YES, amount sought $_____ Please attach a copy of your rental agreement.

SECTION 12 - CLOTHING REPLACEMENT

Are any of the victim's cothes being held by the police or prosecuting attorney as evidence? ☐ YES ☐ NO

If YES, what is the reasonable replacement value of the articles of clothing? $ _____ (Limit $100)
No reimbursement when victim is deceased.

SECTION 13 - DECLARATION AND AFFIRMATION

SUBROGATION: If a monetary award is made, I agree to accept it under the provision of D.C. Law 3-429. This law requires that any money received from a civil suit relating to this crime, including settlement, be repaid to the Crime Victims Compensation Program up to the amount awarded under this application

If the District of Columbia desires, it can file suit against the offender for recovery. Should the District of Columbia decide to sue, it will be responsible for all costs incurred and will recover those costs from moneis awarded in the suit. I understand that I must fully cooperate in any such suit instituted by the District of Columbia.

I HEREBY CERTIFY THAT I WILL NOTIFY THE DISTRICT OF COLUMBIA IN THE EVENT THAT I FILE SUIT AGAINST THE OFFENDER OR THE COURT ORDERS THE OFFENDER TO MAKE RESTITUTION TO ME.

I DECLARE UNDER PENALTY OF FINE AND/OR IMPRISONMENT THAT THE INFORMATION CONTAINED IN THIS APPLICATION FOR A CRIME VICTIMS COMPENSATION AWARD IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____
Signature of Claimant Date

_____ _____
and/or Signature and Telephone Number of Person Completing this Form Date

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
CRIME VICTIMS COMPENSATION PROGRAM
515 Fifth Street, N.W., Suite 203
Washington, DC 20001

Name of Claimant
Name of Victim
Claim Number

(Oficial Use Only)

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize and request any person having information necessary to the administration of my claim to release that information, including all past law enforcement records concerning this claim, to the Superior Court of the District of Columbia Crime Victims Compensation Program. This release includes, but is not limited to: private and governmental physicians, mental health service providers, and hospitals; local, state and federal law enforcement agencies or prosecutors' offices; revenue services and court personnel; any employer, private company or governmental agency that is providing, or may provide, medical or monetary benefits. The District of Columbia's Department of Finance and Revenue is specifically authorized to provide the District of Columbia Crime Victims Compensation Program with copies of my District of Columbia tax forms and withholding statements that may be required to make final decision on this claim.

I agree and certify that no person shall incur any legal liability to my by releasing any information pursuant to this authorization. A photo copy of the authorization is as effective and valid as the original.

CLAIMANT'S SIGNATURE

DATE